# Cast A Foot Podiatry, P.C.

Nicole M. Castillo, DPM
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**AUTHORIZATION FOR USE OF SIGNAUTRE ON FILE FOR CLAIM AUTHORIZATION**

Date:_________________
Enrollee Name:___________________
Patient Name:____________________
Social Security#:___________________

I, _______________________________authorize Dr.'s Nicole, Castillo to mark the section "ENROLLEE'S OR AUTHORIZED PERSON'S SIGNATURE" with the notion "SIGNATURE ON FILE."

This section authorizes:

1) The release of any medical information necessary to process claims.
2) Payment of medical benefits to the undersigned physician or supplier of services described below.
3) I give permission to Dr. Nicole M. Castillo and Dr. Emilio A. Goez to administer treatment and to peform procedures as necessary in my diagnosis and/or treatment.

This authorization will remain in force until terminated in writing by the enrollee.

_____________________________ _______________________
Patient Authorized Signature Date

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This section authorizes my understanding and acceptance of health insurance policies and treatment performed by the rendering physician. I understand and agree that health and accident polices are an agreement between an insurance carrier and myself. In case of denial and termination of benefits, I the undersigned, understand that I am responsible for full payment of services rendered. In the event my account is sent for collection, I understand that I am responsible for any fees related to this collection. I agree and authorize treatment to be performed and discussed by the provider.

_________________________________ ________________________
Patient/Authorized Signature Date

_________________________________ ________________________
Physician's Signature Date